Patient Experience Case Studies

Emma's Story:

A woman's wait for hip surgery

October 2009

KPMG

Patient First

Table of Contents

Introduction	1
Emma's Story	2
Issue Highlights	4
Key Questions	4
Case Discussion	5
Discussion on Causes	6
Linking It Back to the Research	7
Leading Practices	9
Interactions with Care Providers	10
Wait List Management and Scheduling	11
Communication	12
Continuous Quality Improvement	12
Requirements for Change	12
Emma's Story Retold	13
References	17

KPMG LLP, a Canadian limited liability partnership established under the laws of Ontario, is the Canadian member firm affiliated with KPMG International, a global network of professional firms providing Audit, Tax, and Advisory services. Member firms operate in 144 countries and have more than 137,000 professionals working around the world. The independent member firms of the KPMG network are affiliated with KPMG International, a Swiss cooperative. Each KPMG firm is a legally distinct and separate entity, and describes itself as such.

Introduction

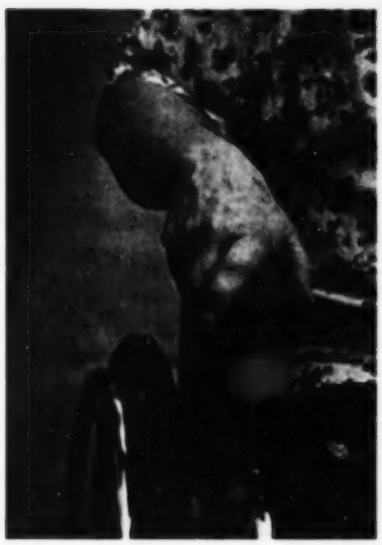
The Patient First Review was a landmark research study within the Province of Saskatchewan which explored the current health care system from a patient's perspective. The research involved speaking with patients, health care providers, and health system stakeholders in order to understand issues within the system, the potential causes of those issues, and what potential solutions might address them.

While the research provided a wealth of information that will be used by the Ministry of Health and the health care system to guide system planning, the Province was interested in doing a more detailed analysis on some of the key issues within the system in order to validate what was heard in the research. The case study approach was determined to be a useful tool for this analysis.

The purpose of Emma's story is to:

- Present a patient story of a typical journey through the system for a hip replacement.
- Engage patients and providers in a deeper discussion on the issues encountered in the system when a patient requires hip replacement surgery.
- Validate the causes of the issues heard in the research.
- Explore potential solutions to address the issues that might be investigated further by the Ministry, health care providers and system stakeholders.
- Present the envisioned patient story when improvements have been made in the system.

The case study focuses on the experience of a woman with osteoarthritis of the hip, as she experiences the health system from the initial interaction with her primary care provider through to recovery at home following hip replacement surgery. The names are fictional; however, the experiences are real. Multiple patients interviewed during the Patient First Review provided an account of their experiences, which were combined to highlight common issues encountered throughout the health care system. Communities named in the study were used only as reference points. The providers referred to in this case are fictional and are not meant to depict any individuals who work in these communities. Any similarity to real people is purely coincidental.



Emma's Story

Emma is a 68-year old woman who recently had a hip replacement. She lives in a town outside a large urban centre in Saskatchewan. She is a single mother of three grown children and still cares for one of her children who has a disability, at home. She is self-employed so that she can maintain her job and care for her child.

With every visit to her family physician, Emma complained of increasing pain, stiffness, and difficulty getting around.

A few years ago Emma started feeling pain in her hip and found it increasingly difficult to walk. During an appointment with her family physician, she complained of the pain and was prescribed Tylenol. At first, the medication appeared to diminish some of the pain, but it became increasingly more painful and difficult for her to get around. The pain started having an impact on her ability to work and care for her daughter.

With every visit to her family physician, Emma complained of increasing pain, stiffness, and difficulty getting around. As a result, her pain medication was increased, and eventually she was prescribed medication for arthritis.

Even with the new medication, the pain continued to impede Emma's ability to work and care for her daughter. She relied more and more on her other adult children to provide care for their sister so that Emma could find time to rest. As Emma's capacity for work deteriorated, her income began to decline to the point that she was forced to investigate options for social assistance. In the meantime, the complexity of scheduling care giving for her daughter among other family members was creating tension in the family. Emma tried to ease the conflict between her children by again taking more responsibility for her daughter's care. However, this only left her more exhausted and reduced her ability to do other activities. Gradually, she eliminated her weekly walk to the local grocery mart, arranging for groceries to be delivered to her home. She cancelled her membership at the nearby swimming pool, as she was too sore and tired to make use of it.

As Emma's capacity for work deteriorated, her income began to decline to the point that she was forced to investigate options for social assistance.

After two years of suffering, Emma urged her family physician to refer her to a specialist about her hip pain. She also told her doctor about her concerns of the side effects of the medications she had been taking over the past several years, having heard from her son that excessive doses of Tylenol could interfere with liver function.

Her physician agreed to refer her to an orthopaedic surgeon. Emma waited six months for her consultation visit with the orthopaedic surgeon. On the day of her visit, the specialist took her medical history, asked her to explain the problem, and examined her. He then told her that she would have to go for several tests to determine if she was a good candidate for surgery.

Emma received a CT scan six months later, and because of a cancellation in her orthopaedic surgeon's schedule was able to see him within two weeks after the scan was completed. The CT scan indicated that Emma's hip joint had significantly deteriorated and required surgery. Emma was put on a wait list and was told her surgery would be scheduled as soon as possible, but that it may take up to twenty-four months.

After six months had passed, Emma felt that her condition was deteriorating and was concerned that she hadn't heard anything about her surgery date. She didn't want to leave the house that summer, which resulted in her staying home from her usual camping trip with her daughter to wait by the phone.

At her wit's end, and not knowing who to contact for help, Emma phoned her local health region's administrative office. After being redirected a couple of times, she was advised to call the region's "client representative." She did so but was given the same response she had received from the specialist: that she was on the list, but that it could be up to twenty-four months before she received surgery.

Emma was put on a wait list and was told her surgery would be scheduled as soon as possible, but that it may take up to twenty-four months.

After another two months, and still no information on her surgery date, Emma broke down crying during a visit with a close friend. Concerned about Emma's state of mind and overall health, her friend called upon a specialist who was a long-standing acquaintance. The specialist said he would try to get Emma's surgery date moved up. Emma was called the following week, and her appointment was scheduled for one month from that day. She was also scheduled for a pre-operative appointment within two weeks.

During the pre-operative appointment, Emma spent a full day with numerous health professionals who conducted a variety of assessments, consultations, and tests. At the end of the day she returned home exhausted and overwhelmed with information.

The day before her surgery, Emma spent the morning getting pre-operative tests done to ensure she was still a candidate for surgery. The next day, nervous but anticipating the relief of her pain, she was contacted by the hospital and told that her surgery had to be rescheduled due to a lack of bed availability, because an emergency medical patient required her bed overnight.

After several days of waiting, she was called and told that her surgery would be within the week. On the day of her surgery she was fearful that her procedure would be cancelled again. She was prepped for surgery and the procedure went smoothly.

After another two months, and still no information on her surgery date, Emma broke down crying during a visit with a close friend.

Emma's pain was well-managed in recovery, and throughout the rest of her stay in hospital. However, as an after-effect of the surgery, she frequently needed to urinate and had to call upon the nurses each time to assist her. Late in the evening, when her call wasn't immediately responded to, she pressed the button again and again as her need to urinate grew more intense. Finally, two nurses walked into her room; one greeted her by saying, "We can't be in two places at once, dear. This isn't the Hilton." Startled, Emma slunk down in the bed and urinated. She didn't move the rest of the night, upset and afraid to impose on the nursing staff.

On the second day after her procedure, a discharge planner came to discuss with her what she would need to help support herself in her home in terms of equipment, and discussed the need for physiotherapy based on her physician's orders.

On the fourth day, Emma was sent home and felt she was well prepared for her recovery at home. Physiotherapy services were arranged at a facility closer to her home.

... nervous but anticipating the relief of her pain, she was contacted by the hospital and told that her surgery had to be rescheduled due to a lack of bed ...

In the end, Emma looked back and wished she had pushed her family physician sooner for a specialist appointment. She had lived with the pain for so long she hadn't realized what a difference surgery would make in her life. Now her other hip is starting to feel the same pain and she fears having to live through the process a second time.

Issues Highlights

Emma's story serves to highlight the following system issues:

- Long wait times for elective surgeries;
- A lack of communication on an estimated date for the procedure;
- A lack of care for patients while they are on the wait list;
- Rude or uncaring staff;
- A lack of involvement of the patient in the range of options to help alleviate their condition; and
- Poor connections among providers in the system -- for example, among family physicians and specialists, and between hospitals and home care in the coordination of discharge.

Key Questions

She had lived with the pain for so long she hadn't realized what a difference surgery would make in her life ... .

- How could Emma's family physician have behaved differently to change her outcome?
- What are some of the incentives or disincentives that contributed to her family physician's behaviour?
- What could have been done to provide Emma with more information on her wait or support her through the wait for surgery?
- How can instances of rude or inappropriate behaviour by care providers be addressed?
- Are there ways to reduce wait times for surgery or diagnostic testing beyond adding additional staff and infrastructure?
- Are there ways to better coordinate care / pre-surgical educational sessions to meet the patient's needs?

Case Discussion

From a high-level perspective, the experience Emma lived through describes that of a patient who is seemingly on her own to navigate through a "system" not designed as a system. For Emma, this was not a system that was designed to consider her health goals.

Overall, the patients interviewed for this case study described their experience with hip and knee replacement as excellent. This was in reference to the actual procedure, the follow-up care they received in hospital and the transition to home and follow-up care. For the most part, they reported that their pain was very well managed and there was a consistency with which staff conducted themselves.

The primary complaints about this process from the patients involved the experience of waiting for surgery, the lack of information provided, and the impact this had on their lives. Often, patients are not provided with an estimated date for their elective surgery and can continually be told their surgery date estimate has been pushed back. They don't even receive this information unless they take the initiative to call client representatives / quality care coordinators themselves and are not informed otherwise until a date is scheduled.

In the interim, patients' conditions can deteriorate and it is up to them to seek appropriate care options to help them manage through the wait. If Emma had diabetes, for example, her limited mobility and physical deterioration would have had an impact on her ability to maintain an adequate exercise regimen and would have likely made it more difficult for her to control her blood sugar levels.

Depending on the severity of her diabetes, this may have had an impact on her capacity to undergo surgery after a significant wait. Luckily, Emma did not have diabetes or other co-morbid conditions that may have made it more difficult for her to cope through the wait for surgery.

For Emma, this was not a system that was designed to consider her health goals.

Emma was, however, self-employed and had a dependent child, which required her to be mobile. Additionally, if she had been employed and on sick leave or disability benefits, there may have been additional resources to help her get back to work sooner. Emma also felt she should have pushed her physician to see the specialist. She blamed herself for living in pain for two years before speaking up. She was not fully engaged by her physician in a discussion on her options for managing her pain and a complete diagnosis of her pain was not determined. She also relied on a strong advocate to help her case in moving up her surgery date, something not everyone in the system can rely on.

There were other system issues highlighted in Emma's case that are not uncommon for patients having elective surgery. During times of overflow in the hospital, providers indicated that medical patients can be bed-spaced in the surgical wards. This has resulted in elective surgery cancellations. Surgeries can also be cancelled before a patient is admitted, but also after they are admitted and prepped for surgery if they are displaced by an emergent procedure.

Emma also spent a significant amount of time in the pre-admission clinic meeting with each professional individually. She indicated that throughout this day there was a lot of waiting between meetings with each professional and that by the end of the day she was a bit overwhelmed with all the information she was expected to absorb. This is consistent with the findings from the patient research, which indicated a lack of coordinated care for simple things such as scheduling.

She blamed herself for living in pain for two years before speaking up. She was not fully engaged by her physician in a discussion on her options for managing her pain and a complete diagnosis of her pain was not determined.

For the most part, Emma experienced friendly, courteous staff, with the exception of a few individuals. While these individuals are few and far between, they do leave a lasting mark on her experience with the whole procedure. It was an undignified experience that she should not have had to experience in any circumstance.

In the end, the hospital used surgical care maps to guide her surgical procedure; steps before, during and after her surgery, that Emma felt created a smooth experience in the hospital and during the transition to home and follow-up care.

Discussion on Causes

In discussions with providers and staff from the Ministry of Health, there are potentially several issues driving the care Emma experienced.

Individuals and organizations across the health care system are working primarily in silos, each one doing a relatively good job at what they do. However, the care processes as experienced by Emma were not designed across the entire system. They have also not been designed from end to end with the patient experience in mind. The infrastructure and supports required to support these efforts are not in place (e.g. incentives for cross-collaboration, shared outcome measures and accountability for the patient experience etc.).

These patient experiences prompted the Saskatchewan Surgical Care Network and the four regions providing total joint replacements to develop a Provincial Hip and Knee Pathway that was piloted in 2008-09 and began full implementation on April 1, 2009. This pathway developed a new process from the patient's first visit with their family physician through assessment and surgery and post-surgical rehabilitation.

These patient experiences prompted the Saskatchewan Surgical Care Network and the four regions providing total joint replacements to develop a Provincial Hip and Knee Pathway ...

A cornerstone of the Pathway is the Multi-Disciplinary Clinic. Family practitioners refer patients to the clinic for assessment and triage. Four clinics are being established in Saskatchewan – in Regina, Saskatoon, Prince Albert and Moose Jaw. At the clinic, patients are provided with individually tailored information on their condition, exercise programs, assistance with getting the right equipment, and if surgery is indicated, preparing for surgery and post-surgical discharge. The clinics co-ordinate the patient's journey through surgical booking, diagnostic tests and pre-surgical education for the patient and their coach.

Each region has developed system flow processes, new ward flow processes and new operating room processes. These are aimed at improving both efficiency and quality of care. Outcome measures for the program include safety and volumes measures as well as quality-of-life outcome measures.

At a regional and inter-regional level, there appears to be a lack of systematic utilization management. This would help determine whether there was

appropriate capacity in the system, including the appropriate number of beds, the requirement for surge protocols and advanced discharge planning practices. To demonstrate, Alternate Level of Care Days (ALC) were estimated to be 7 per cent for all hospitals in Saskatchewan for 2007/08 (DAD, 07/08). Rates of Ambulatory Care Sensitive Conditions (ACSC) were reported to be the fourth highest in Canada at 614 visits per 100,000 population. ACSC represents high volumes of hospitalizations that could otherwise potentially be cared for in the community (CIHI, 2008). Typically, bed occupancy rates above 85 to 88 per cent cause blockages and inefficiencies in patient flow. In 2007/08, Medical/Surgical wards in the major centres were well above this rate (Royal University 92 per cent, Regina General 101 per cent, Yorkton Regional 106 per cent, Victoria Hospital 95 per cent). Combined, these factors are contributing to bed spacing (overflow) of medical patients into surgical wards and surgery cancellations.

This lack of available leadership in clinical areas contributes to decreased staff satisfaction, which leads to a decreased quality of care and a negative patient experience.

We also heard from providers and patients that capacity issues were constraining wait times due to a lack of operating room time for surgeons, or bed spacing issues. Based on the experiences of other jurisdictions, it is likely that there is a range of issues causing wait lists that would require a complete analysis. This analysis would include an assessment of appropriate demand and referral, scheduling algorithms and queuing theory, and capacity within the system to meet demand.

Interviews with staff also indicate they found it difficult to access supervisors and management staff when needed. This lack of available leadership in clinical areas contributes to decreased staff satisfaction, which leads to a decreased quality of care and a negative patient experience. This was consistent with the research that linked many of the issues to a lack of supervisory management at the clinical unit level.

Linking it Back to the Research

Throughout the Patient First Review research, patients and providers relayed themes consistent to those presented in this case. The experiences and the causes of these experiences are described below and are consistent with the causes as described by patients and providers interviewed for these in-depth case studies and the data that has been presented to assess them.

The themes and causes as relayed by patients and providers consistent with this case include the following:

Theme – Quality of interaction between providers and patients

This cause theme is described as low-quality face time with physicians (e.g. lack of two-way communications, inattentiveness in examination, over-prescription).

Low-quality relationships are driven by:

- Rushed appointments
- Dismissive behaviours
- Lack of clarity in communications
- Over-prescription
- Lack of follow-up

Physicians' performance is affected by:

- Impact of fee-for-service compensation model
- Time crunch
- Stress

Theme – Effectiveness of communication channel between the system and patient

This cause theme is described as poor communication with patients from hospitals, facilities, doctors' offices (e.g. no orientation to the hospital, no updates on waits for service, test results, next steps); no one takes responsibility for the patient file.

- Not being kept apprised of updates and timing
- No advocate (although in Emma's case, she was fortunate to have an advocate where most people would not)
- Poor communications of wait times for surgery
- Lack of consistent standards for patient-provider communication of test results and diagnosis
- Inadequate sharing of information from providers on what to expect after discharge

Theme – Coordination/organization of care throughout the continuum

- Referrals to specialists
- Lack of efficiencies in referral processes and patient transfers through the health care system
- Providers rely on their own insular network of colleagues for referrals without exploring faster or potentially more convenient options
- Waiting for surgeries
- Poor coordination and organization of wait lists
- Poor coordination and inadequate allocation of surgical time for surgeons
- Wait lists are not well quarterbacked – contact with patients should be more frequent to confirm efficiency of scheduling and to avoid cancellation
- Flow issues – bottleneck in the system which is caused by a large backlog

For the most part, these are consistent with the care Emma experienced. Patients interviewed who had an elective hip or knee surgery talked about a smooth transition between hospital and home and felt well informed about how to care for their wounds and take care of their health. Those who had urgent or emergent surgery that may not have followed a routine care path felt less informed, and the transition and supports, particularly across regional boundaries, were less well managed.

Leading Practices

One of the goals of the Patient First Review is to examine all aspects of care with the patient in mind. A common framework developed by the Institute of Medicine (IOM) in 2001 proposed six aims for a healthcare system. This framework can be helpful when analyzing the care process experienced by Emma. They include the following:

- Safe – avoiding injuries to patients from the care that is intended to help them.
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- Patient-centered – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely – reducing waits and sometimes harmful delays for those who receive care and those who give care.
- Efficient – avoiding waste, in particular waste of equipment, supplies, ideas and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Through this lens, the care experienced by Emma did not fulfill any of these aims completely. The system as it exists today requires a re-orientation towards consideration for the patient in all aspects of care. This would begin by first defining the "patient" and what it means to be patient-centered.

Don Berwick, the CEO of the Institute for Healthcare Improvement and a strong advocate for patient-centred care defines patient (and family) centered care as follows:

> *The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care (Berwick, 2009).*

Berwick suggests how a system under this definition might be different as follows:

- Hospitals would have no restrictions on visiting – no restrictions of place or time or person, except restrictions chosen by and under the control of each individual patient.
- Patients would determine what food they eat and what clothes they wear in hospitals (to the extent that health status allows).
- Patients and family members would participate in rounds.
- Patients and families would participate in the design of health care processes and services.

The system as it exists today requires a re-orientation towards consideration for the patient in all aspects of care.

- Medical records would belong to patients. Clinicians, rather than patients, would need to have permission to gain access to them.
- Shared decision-making technologies would be used universally.
- Operating room schedules would conform to ideal queuing theory designs aimed at minimizing waiting time, rather than to the convenience of clinicians.
- Patients physically capable of self-care would, in all situations, have the option to do it.

... her family physician could have been more engaging if the physician had asked Emma questions about her pain and the limitations on her mobility.

This is a useful framework that can guide the development of patient-centred care across the system beyond the issues highlighted in this case. However, it is important that Saskatchewan develop its own definitions and frameworks based on its own values. These can be informed by those developed in other jurisdictions, but must also accompany explicit actions for what it means to be patient-centred at each patient touch-point.

Interactions with Care Providers

The framework proposed by IOM provides a useful tool for analysing the issues encountered by Emma in her experience with the health care system.

To begin with, the interaction with her family physician could have been more engaging if the physician had asked Emma questions about her pain and the limitations on her mobility. Often, interactions with medical professionals are episodic, trying to target rapid diagnosis and treatment without concern for the health of the patient beyond physical characteristics.

After the determination that Emma wasn't able to adequately cope with the pain, she could have been engaged in a discussion on a range of options to help her manage her pain including the option to see a specialist and the risks involved, providing her with adequate education to help her make an informed choice.

The new pathway process currently being piloted in the province includes a physician referral tool that uses leading practice guidelines to determine a patient's level of pain and function. This tool helps inform the clinician and the multi-disciplinary clinic of the appropriate medical interventions for the patient, either as a medical treatment option, or to assist them in preparing for a successful surgical experience. As part of a patient-centred approach, during the surgical experience patients will also have the choice of anaesthesia (spinal or general) to provide them with options that suit their needs.

Throughout the care process, Emma encountered friendly, helpful, courteous staff with the exception of a few individuals that provided exceptionally inappropriate care. The underlying root causes of these interactions requires further investigation, but can also partially be attributed to a lack of leadership on the units. Staff indicated that supervisors were stretched thin and were responsible for multiple units, many times in different physical locations, in essence making them part-time managers. To help support supervisors and management staff, care behaviours must also be engrained in the performance management system so that staff know which behaviours are acceptable and which are not.

Wait List Management and Scheduling

A major recent focus of the Ministry of Health has been the improvement of wait times for surgeries and diagnostic imaging. This area of focus will remain a priority and should continue to show improvement.

Current wait list management in the province as described in Emma's story is tied to the provider and suited to meet their needs. Very little information was provided to Emma to help her plan and prepare mentally for her wait and surgery. Education is a key feature of the new pathway process that stresses patient involvement in their care through informed decision making and responsibility for managing the self-care portions of the program. The patient is required to bring along a "coach", usually a family member, to the clinics and education sessions. Increased efforts should be made to provide more accurate estimates of the patient's surgery date. The patient should also be called immediately upon registering on the wait list. The new care pathway supports patients through their wait process that could include pain management, chronic disease management and counselling.

Education is a key feature of the new pathway process that stresses patient involvement in their care through informed decision making and responsibility for managing the self-care portions of the program.

Leading practice involves the use of simulation modelling and queuing theory to manage wait lists and scheduling surgeries that includes triaging patients based on need (e.g. high risk diabetes patients have a higher priority) and adjusting to suit the needs of the individual patient (Gorunescu et al, 2002). Leading practice also employs the use of centralized assessment, and assignment of the first available surgeon that can meet the needs of the patient, or providing patients with the option to take the first available surgeon. In a centralized queue, equity is upheld and all patients wait less. These concepts have been used in the development of the clinical pathway and initiatives to improve patient flow.

Centralized assessment can by conducted by an advanced practice physiotherapist who can field referrals from family physicians, meet with the patient if necessary to assess their candidacy for surgery, and provide the patient the option of referral to the first available physician (MacLeod et al, 2009). The patient is also provided with options to manage their pain and care throughout their wait for surgery. The use of an advanced practice physiotherapist and centralized assessment optimizes the use of the surgeon to focus only on those cases that are candidates for surgery.

The new care pathway supports patients through their wait process that could include pain management, chronic disease management and counselling.

There may also be opportunities to optimize operating room scheduling to maximize patient throughput, including the application of systematic utilization management (Dexter et al., 1999; Calichman, 2005, Aleman, 2009).

The Institute for Healthcare Improvement advocates for the systematic assessment of care processes to increase efficiencies and reduce delays/ wait times without the need to add additional staff. They have adopted a model for improvement developed by Langley et al. that follows a logical assessment that identifies "What are we trying to accomplish", "How will we know when a change is an improvement", and "What changes can we make that will result in improvement". It implements the Plan-Do-Study-Act cycle of continuous improvement (IHI, 1996).

This approach (IHI, 1996) identifies multiple tools and processes useful for addressing the core issues causing delays and wait times. For surgical processes these include the following:

- Use of control charts to study variation in case length;
- Optimizing the surgery team, rather than operating room utilization;

- Standardizing operating rooms to maximize their flexibility;
- Scheduling unpredictable cases at the end of the day or in a separate room; and,
- Study reasons for delays and focus improvement efforts on unnecessary delays.
- These efforts help to reduce specific issues and help to address delays in the surgical process to optimize care.

Communication

As proposed by IOM, an aspect of patient-centered care is providing the patient with information throughout their journey to help them continually assess their situation, put them at ease, and to allow them to make decisions based on that information.

In Emma's case, this would have included having a medical professional contacting Emma immediately after she was registered on the wait list to explain what this meant, how long she could expect to wait and to provide her with information on managing her health while she waited for surgery.

As someone who is self-employed, she would have to make decisions as to whether her condition was going to impact her ability to provide income for herself and her dependent child.

Continuous Quality Improvement

Additionally, capturing patient input on their experience throughout the care process is a critical step towards continuous quality improvement. In addition to randomized surveys, leading practice employs listening posts that include, for example, focus groups, walkthroughs, complaint/compliment letters and patient and family advisory councils (Edgman-Levitan, 2008). These methods can be employed to provide innovative ideas for improving care delivery and involving patients in the redesign of the care process.

Changing the care she experienced requires a fundamental shift in the way care is provided. This includes examining every aspect of care to assess whether it is patient-centered.

Requirements for Change

There are many underlying factors that contributed to Emma's experience. Changing the care she experienced requires a fundamental shift in the way care is provided. This includes examining every aspect of care to assess whether it is patient-centered. In order to support these changes the following supports are required:

- Vision - to support patient-centered care we first need to define what it means, and what it means to support and implement patient-centered care and policies.
- Leadership – management that is accessible to staff in care units, and leadership that understands the impact each action has on the patient experience.
- Accountability – a system that makes each individual in the care process accountable for the patient experience for each touch-point throughout the patient journey.
- Supports – supports for staff and clinicians that enable patient-centered care.
- A change in behaviour – for staff, behaviours should be defined in performance management systems.

Emma's Story Retold

A few years ago, Emma started feeling pain in her hip and increasingly found it difficult to walk. During a trip to her family physician, she complained of the pain in her hip. Her family physician engaged her in a conversation about the pain and the impact it was having on her mobility and her life. After Emma indicated she had been living with the pain for some time and it was starting to significantly impact her mobility, her doctor said she would immediately prescribe some Tylenol. She said she would follow up with her in a few days to see if the prescription was helping her pain. If it wasn't, she may have to come back in for a higher dosage. In the meantime, she would be scheduled to have x-rays which, she was told, would help determine what was causing her pain.

Emma's doctor also discussed her options for surgery and said she would make a referral to the Hip and Knee program for an assessment if the x-rays showed any arthritis or other reason that may warrant a referral. Her doctor mentioned that they would assess whether she was a candidate for surgery, and that they would discuss options with her for managing her pain if she was not a candidate. On her way out of her doctor's office, the receptionist booked Emma into an x-ray appointment at the local diagnostic imaging centre. The next available appointment was within the week.

A few days after her x-ray, Emma received a call from her doctor indicating that she did have significant osteoarthritis and that she would put forward the referral. She was told to expect a call from the centre within a week, and reminded her that they would assess her candidacy for surgery. If she was not a candidate, they would sit down together and come up with a plan to help her manage the pain and the impact it could have on her life.

Within two days, Emma received a call from the assessment centre asking her when she would be available for an appointment. They explained that she would be assessed by an advanced practice physiotherapist (APP) and that they would discuss Emma's options during the visit, one of which may include surgery. The assessment centre, she was told, would determine whether she would proceed to a consultation by a surgeon.

Emma attended the assessment within two weeks. The APP assessed her clinical, functional and radiological findings and determined that she was a candidate for surgery and that she had a choice of several surgeons, each with varying waiting times, or if she had no surgeon preference, she could be seen by the first one available. She would first have to visit with the surgeon who would walk her through the surgical process, discuss the risks and confirm the assessment.

The APP also gave her tips on how to manage her pain and offered to refer her to a pain management clinic if she felt the pain was unmanageable with only prescription medication during her wait for surgery. Emma was also given a nutritional plan and advice on the appropriate physical activities to improve function and to assist with her post-op recovery. They gave her a 1-800 number to call if she ever had any questions, or if she wished to be referred to the pain management clinic. Emma was scheduled to see the surgeon for consultation within two months.

She had a choice of several surgeons, each with varying waiting times, or if she had no surgeon preference, she could be seen by the first one available.

Emma selected a surgeon in Prince Albert. Although it was a bit farther for her to travel, it was estimated that she would not have to wait as long as she would for a surgeon in Saskatoon. During her consultation with the surgeon, he discussed her surgery, the risks involved and what she could expect in terms of recovery. He told her that she should receive a call within the week to schedule her surgery and that the current wait was approximately three to four months.

During her consultation with the surgeon, he discussed her surgery, the risks involved and what she could expect in terms of recovery. He told her that she should receive a call within the week to schedule her surgery and that the current wait was approximately three to four months.

The next day, she was called to schedule her surgery and booked an appointment for the pre-admission clinic. She was also asked how she was managing her pain, and her life situation. She was scheduled to have surgery within three months.

During her visit to the pre-admission clinic a week before her surgery, she met with a nurse practitioner, physiotherapist and dietician who together provided her with information on the surgery and the procedure while in hospital. They also provided her with some information on how to care for herself after her surgery. Immediately following, the anesthetist and her surgeon met with her together to explain the details of the surgery, review the risks with her and answered any final questions she had. After she had some blood drawn and a few final tests, she was scheduled for a home assessment. She was told that someone would come by her home to provide some guidance on how to get around after surgery and the equipment she would need.

Emma had her surgery a week later and was cared for by courteous staff and physicians. A day before she was discharged, someone came in to ask her how her stay was and whether there were things that could be changed to help her immediate experience, or for future patients. She was scheduled for a follow-up visit with her surgeon and physiotherapy services close to her home. She was discharged home and a few days later she was visited by a nurse to see how she was coping and to check whether she was adequately caring for her wound.

A few weeks later Emma received a survey asking her to answer questions on the care she received through her care process. Emma felt supported throughout the journey and rated her care as very satisfactory. At the end of the survey she was asked to consider participating in a focus group to help improve the patient experience and was provided with a number to call if she had suggestions for improvement.

Because Emma's pain was addressed proactively, and her surgery expedited within a reasonable timeframe, she was able to continue caring for her daughter and was much less reliant on other family members to share the care giving burden.

Because Emma's pain was addressed proactively, and her surgery expedited within a reasonable timeframe, she was able to continue caring for her daughter and was much less reliant on other family members to share the care giving burden. The reduced number of appointments meant less time away from her daughter and more ability to continue with her income-generating activities.

In the end, the care Emma initially received could have improved through a focus on her needs. At each touch point with the patient this would require reflection on the impact actions or inactions have on the patient experience. The experience changed, not because of a single initiative, but through multiple initiatives to change the way care is provided across the system.

The table below demonstrates the touch points at each stage in Emma's care journey and the impact on her. The table also provides suggestions for how improvements could be made to each touch point, and links those aims with current/planned initiatives within the Province of Saskatchewan. It is important to reflect on each of the touch points through the case, because it is these touch points that can make or break the overall patient experience.

Touch Point	Emma's Story	Improvement Aim	Current MOH Initiatives
Describing symptoms with the Family Physician	Episodic, treatment of the symptoms.	Holistic care Listen to patient needs Engage patient in a discussion of options	Advanced Access
Referral to specialist	Long Waits Duplicate information sharing	Shorten wait time Shared electronic health records	Integrated care pathway Multi disciplinary assessment and triage clinics Physician referral guide web site Surgical Capacity Initiative EHR
Put on the wait list	No communication on estimated date of surgery No follow-up care provided while on the wait list	Full communication with choice of dates Follow-up care provided to help patients manage while on wait list physically, mentally and economically	Hip and Knee Pathway with education, physio, nursing, pharmacology, nutritional and kinesiology support
Surgical Procedure	Cancellations Rude, uncaring staff	Reduce cancellations Every provider interaction is caring and supportive	Surgical capacity initiative Hip and Knee Initiative

References

Aleman, D. S Azari-Rad, M Escudero, D Urbach (2009). A Decision Support Tool for Operating Room Scheduling Under Deadlines and Emergency Surgery Disruptions. Centre for Reasearch in Healthcare Engineering. Website accessed June 1, 2009: http://crhe.mie.utoronto.ca/research/detail.php?cat=ops&id=6

Berwick, D. (2009). What Patient-Centered Should Mean: Confessions of an Extremist. *Health Affairs,* May 2009.

Canadian Institute for Health Information / Statistics Canada (2008). Health Indicators.

Calichman, M (2005). Creating an Optimal Operating Room Schedule. *AORN Journal,* March 2005.

Dexter, F. A Macario, R Traub, M Hopwood, D Lubarsky (1999). An Operating Room Scheduling Strategy to Maximize Use of Operating Block Time: Computer Simulation of Patient Scheduling and Survey of Patients' Preferences For Surgical Wait Time. *Anesthesia and Analgesic;* 89 pp. 7-20.

Edgman-Levitan, S. (2008). Measuring and Improving Patient Experiences of Care. Chapter in: *The Healthcare Quality Book: Vision, Strategy and Tools; 2nd Edition.*

Gorunescu, F. S McClean, P Millard. (2002). A Queuing Model for Bed-Occupancy Management and Planning of Hospitals. *Journal of the Operations Research Society;* 53 pp.19-24.

Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century.* National Academy Press; Washington DC.

MacLeod, AM. J Gollish, D Kennedy, R McGlasson, J Waddell. (2009). Toward a Joint Health and Disease Management Program. *Healthcare Quarterly* 12(2).

This case study was prepared by:

For more information, contact:

Saskatchewan Ministry of Health
T.C. Douglas Building
3475 Albert Street
Regina, Saskatchewan
S4S 6X6

General Inquiries: (306) 787-0146
Toll-free: 1-800-667-7766 (Saskatchewan only)
E-mail: info@health.gov.sk.ca

www.health.gov.sk.ca/patient-first-review/

Saskatchewan Ministry of Health